# General

## Guideline Title

Substance misuse and alcohol use disorders. In: Evidence-based geriatric nursing protocols for best practice.

## Bibliographic Source(s)

Naegle M. Substance misuse and alcohol use disorders. In: Boltz M, Capezuti E, Fulmer T, Zwicker D, editor(s). Evidence-based geriatric nursing protocols for best practice. 4th ed. New York (NY): Springer Publishing Company; 2012. p. 516-43.

## Guideline Status

This is the current release of the guideline.

This guideline updates a previous version: Naegle M. Substance misuse and alcohol use disorders. In: Capezuti E, Zwicker D, Mezey M, Fulmer T, editor(s). Evidence-based geriatric nursing protocols for best practice. 3rd ed. New York (NY): Springer Publishing Company; 2008. p. 649-76.

# Regulatory Alert

## FDA Warning/Regulatory Alert

Note from the National Guideline Clearinghouse: This guideline references a drug(s) for which important revised regulatory and/or warning information has been released.

- August 31, 2016 – Opioid pain and cough medicines combined with benzodiazepines : A U.S. Food and Drug Administration (FDA) review has found that the growing combined used of opioid medicines with benzodiazepines or other drugs that depress the central nervous system (CNS) has resulted in serious side effects, including slowed or difficult breathing and deaths. FDA is adding Boxed Warnings to the drug labeling of prescription opioid pain and prescription opioid cough medicines and benzodiazepines.
- March 22, 2016 – Opioid pain medicines : The U.S. Food and Drug Administration (FDA) is warning about several safety issues with the entire class of opioid pain medicines. These safety risks are potentially harmful interactions with numerous other medications, problems with the adrenal glands, and decreased sex hormone levels. They are requiring changes to the labels of all opioid drugs to warn about these risks.

# Recommendations

## Major Recommendations

Levels of evidence (I–VI) are defined at the end of the "Major Recommendations" field.

Parameters of Assessment

- Screening for alcohol, tobacco, and other drug use is recommended for all community-dwelling and hospitalized older adults. It is essential that the nurse:
  - State the purpose of questions about substances used and link them to health and safety.
  - Be empathic and nonjudgmental; avoid stigmatic terms such as *alcoholic*.
  - Ask the questions when the patient is alcohol- and drug-free.
  - Inquire re: patient's understanding of the question (Aalto, Pekuri, & Seppä, 2003 [Level III]).
- Assessment and screening tools
  - The Quantity Frequency (QF) Index (Khavari & Farber, 1978 [Level VI]): *Review all classes of drugs*: alcohol, nicotine, illicit drugs, prescription drugs, over-the-counter (OTC) drugs, and vitamin supplements, for each drug used. *Record the types* of drugs, including types of beverages; *Frequency*: the number of occasions on which the drug is consumed (daily, weekly, monthly); *Amount of drug consumed* on each occasion during the last 30 days. The psychological function, what the drugs does for the individual, is also important to identify. The QF Index tool should be part of the intake nursing history. The "brown bag" approach is also useful. Ask the patient to bring all drugs and supplements he or she uses in a brown bag to the interview.
  - Short Michigan Alcohol Screening Test-Geriatric Version (SMAST-G): Highly valid and reliable, this is a 10-item tool that can be used in all settings. Three minutes for administration. This instrument is derived from the Michigan Alcohol Screening Test-Geriatric Version (MAST-G) with a sensitivity of 93.6% and positive predictive value of 87.2% (Blow et al., 1992 [Level III]).
  - The Alcohol Use Disorders Identification Test (AUDIT): This 10-item questionnaire has good validity in ethnically mixed groups and scores classify alcohol use as hazardous, harmful, or dependent. Administration: 2 minutes. Sensitivity scores range from 0.74% to 0.84% and specificity around 0.90% in mixed age and ethnic groups (Allen et al., 1997 [Level III]). This instrument is highly effective for use with older adults (Roberts, Marshall, & MacDonald, 2005 [Level III]). Its derivative, the Alcohol Use Disorders Identification Test-Condensed (AUDIT-C), is composed of three questions that have proved equally valid in detecting an alcohol-related problem.
  - Fagerström Test for Nicotine Dependence: This six-question scale provides an indicator of the severity of nicotine dependence: scores less than 4 (*very low*); 4 to 6 (*moderate*), and 7 to 10 (*very high*). The questions inquire about first use early in the day, amount and frequency, inability to refrain, and smoking despite illness. This instrument has good internal consistency and reliability in culturally diverse, mixed-gender samples (Pomerleau et al., 1994 [Level V]).
- Atypical presentation: Men and women older than 65 years may have substance use and dependence problems even though the signs and symptoms may be less numerous than those listed in the *Diagnostic and Statistical Manual of Mental Disorders* 4th ed., text revision (DSM-IV TR).
- Signs of central nervous system (CNS) intoxication (i.e., slurred speech, drowsiness, unsteady gait, decreased reaction time, impaired judgment, disinhibition, ataxia):
  - Assess by individual or collateral (speaking with family members) data collection, detail the consumption of amount and type of depressant medications including alcohol, sedatives, hypnotics, and opioid or synthetic opioid analgesics.
  - Obtain a blood alcohol level. Marked intoxication 0.3% to 0.4%, toxic effects occur at 0.4% to 0.5%, coma and death at 0.5% or higher.
  - Assess vital signs and determine respiratory, cardiac, or neurological depression.
  - Assess for existing medical conditions, including depression.
  - Arrange for emergency room or hospitalization treatment as necessary.
  - Obtain urine for toxicology, if possible.
  - Assess for delirium that can be confused with intoxication and withdrawal in the older adult.
- At-risk drinking is regular consumption of alcohol in excess of one drink per day for 7 days a week or more than three drinks on any one occasion.
  - Assess for readiness to change behavior using stages of change model (Prochaska & Di Clemente, 1992 [Level II]).
  - Is drinker concerned about amount or consequences of the drinking? Has she or he contemplated cutting down?
  - Does she or he have a plan for cutting down or stopping consumption?
  - Has she or he previously stopped but then resumed risky drinking?
  - Personalized feedback and on "at-risk drinking" results in a reduction in at risk drinking among older primary care patients.
- Treatment of acute alcohol withdrawal syndrome (guidelines are modified for other CNS depressant drugs such as barbiturates, heroin, sedative hypnotics):
  - Assess for risk factors: (a) previous episodes of detoxification; (b) recent heavy drinking; (c) medical comorbidities including liver disease, pneumonia, and anemia; and (d) previous history of seizures or delirium (Wetterling et al., 2006 [Level III]).

- Assess for extreme CNS stimulation and a minor withdrawal syndrome evidenced in tremors, disorientation, tachycardia, irritability, anxiety, insomnia, and moderate diaphoresis. When these signs are not detected, life-threatening situations for older adults often result. When these signs are not detected, life-threatening situations for older adults often result. Withdrawal, occurring 24 to 72 hours after the last drink, can progress to seizures, hallucinosis, withdrawal delirium, extreme hypertension, and profuse diarrhea from 4 to 8 hours and for up to 72 hours following cessation of alcohol intake (delirium tremens [DTs]).
- Assess neurological signs, using the Clinical Institute Withdrawal Assessment for Alcohol, Revised (CIWA-Ar). This CIWA-Ar is a 10-item rating scale that delineates symptoms of gastric distress, perceptual distortions, cognitive impairment, anxiety, agitation, and headache (Sullivan et al., 1989 [Level III]).
- Medicate with a short-acting benzodiazepine (lorazepam or oxazepam) in doses titrated to patient's score on the CIWA-Ar, patient's age and weight; use one third to one half recommended dose (Amato et al., 2010 [Level I]). Continue CIWA-Ar to monitor treatment response.
- Provide emotional support and frequent reorientation in a cool, low stimulation setting; monitor hydration and nutritional intake. Give therapeutic dose of thiamine and multivitamins.

- Reported sleep disturbance, anxiety, depression, problems with attention and concentration (acute care):
  - Assess for neuropsychiatric conditions using the mental status exam, Geriatric Depression Scale, or Hamilton Anxiety Scale.
  - Obtain sleep history because drugs disrupt sleep patterns in older persons.
  - Assess intake of all drugs, including alcohol, OTC, prescription, herbal and food supplements, and nicotine. Use "brown bag" strategy.
  - If positive for alcohol use, assess for last time of use and amount used.
  - Assess for alcohol or sedative drug withdrawal as indicated.
- Smoking cigarettes or using smokeless tobacco:
  - Assess for level of dependence using the Fagerström Test (see the Screening Tools for Alcohol and Drug Use section in the original guideline document).

Nursing Care Strategies

- At-risk drinking (consumption of alcohol in excess of one drink per day for seven days a week or more than three drinks on any one occasion) or excess alcohol consumption (more than three or four drinks on frequent occasions):
  - Conduct Screening, Brief Intervention, and as indicated, Referral to Treatment (Substance Abuse and Mental Health Services Administration, 2008 [Level I]):
    - Screen using the AUDIT-C, AUDIT, or SMAST-G.
    - Feedback information to the client about current health problems or potential problems associated with the level of alcohol or other drug consumption.
    - Stress client's responsible choice about actions in response to the information provided.
    - Advice must be clear about reducing his or her amount of drinking or total consumption.
    - Recommend drinking according to National Institute on Alcohol Abuse and Alcoholism (NIAAA) levels for older adults.
    - Provide a menu of choice to the patient or client regarding future drinking behaviors.
    - Offer information based on scientific evidence, acknowledge the difficulty of change, and avoid confrontation. Empathy is essential to the exchange.
- Support self-efficacy. Help client explore options for change.
  - Assist client in identifying options to solving the identified problem.
  - Review the pros and cons of behavior change options presented.
  - Help client weigh potential decisions by considering outcomes.
- Smoking cigarettes or using smokeless tobacco:
  - Apply the 5 As Intervention ("AHRQ clinical practice guidelines," 2002):
    - Ask: Identify and document tobacco use.
    - Advise: Urge the user to quit in a strong personalized manner.
    - Assess: Is the tobacco user willing to make a quit attempt at this time?
    - Assist: If user is willing to attempt, refer for individual or group counseling and pharmacotherapy. Refer to telephone "quitlines" in region or state.
    - Arrange referrals to providers, agencies, and self-help groups. Monitor pharmacotherapy once quit date is established. The U.S. Food and Drug Administration (FDA)-approved pharmacotherapies for smoking cessation are the following:
      - Bupropion sustained release (SR) (Zyban) and nicotine replacement products such as nicotine gum, nicotine inhalers, nicotine nasal spray, and nicotine patch. Nurse-initiated education about these medications is essential
      - Zyban, for example, should not be combined with alcohol. Nurses working with inpatients in a case management model

were found to produce outcomes in smoking cessation (Smith et al., 2002 [Level III])
        - Caring, concern, and provide ongoing support
    - Communicate caring and concern:
        - Encourage moderate intensity exercise to reduce cravings for nicotine because 5 minutes of such exercise is associated with short-term reduction in the desire to smoke and tobacco withdrawal symptoms (Daniel et al., 2004 [Level II]).
        - Arrange: Schedule follow-up contact in person or by telephone within 1 week after planned quit date. Continue telephone counseling especially those using medications and nicotine patches (Boyle et al., 2005 [Level III]; Cooper et al., 2004).
- Alcohol dependence
    - Assess patient for psychological dependence.
    - Assess patient for (a) physiological dependence and (b) "tolerance." Psychological dependence occurs with both abuse and dependence and is more difficult to resolve.
    - Assess for need for medical detoxification (see the Alcohol Withdrawal in Inpatient Hospitalization section in the original guideline document).
    - Refer patient and family to addictions or mental health nurse practitioner or physician.
    - Evaluate patient and family capacity to implement referral.
    - On successful detoxification, monitor use of medications, interpersonal therapies, and participation in self-help groups.
- Marijuana dependence: Little research on effective intervention for psychological dependence on marijuana is available. Some guidance can be found in smoking cessation and self-help approaches.
    - Refer to steps for smoking cessation (see "Smoking Cigarettes or Using Smokeless Tobacco," above).
    - Refer patient to addiction specialist for counseling for psychological dependence and/or cognitive behavioral therapy.
    - Refer to community-based self-help groups such as Narcotics Anonymous, Alcoholics Anonymous, and Al-Anon.
    - Encourage development or expansion of patient's social support system.
- Heroin or opioid dependence
    - Older long-term opioid users may continue use, relapse, and seek treatment. Methadone or buprenorphine are current pharmacological treatment options, effective in conjunction with self-help programs and/or psychosocial interventions.
    - Treatment with methadone, a synthetic narcotic agonist, suppresses withdrawal symptoms and drug cravings associated with opioid dependence but requires daily dosing of 60 mg, minimum. It is dispensed only in state licensed clinics.
    - Buprenorphine (Subutex or Suboxone), recently approved for use in office practice by trained physicians, is an opioid partial agonist–antagonist. Alone and in combination with naloxone (Suboxone), it can prevent withdrawal when someone ceases use of an opioid drug and then be used for long-term treatment. Naloxone is an opioid antagonist used to reverse depressant symptoms in opiate overdose and at different dosages to treat dependence (Centers for Substance Abuse Treatment [CSAT], 2004 [Level VI]).
        - Close collaboration with the prescriber is required because these drugs should not be abruptly terminated or used with antidepressants and interact negatively with many prescription medications
    - Naltrexone, a long-acting opioid antagonist, blocks opioid effects and is most effective with those who are no longer opioid dependent but are at high risk for relapse (Srisurapanont & Jarusuraisin, 2005 [Level III]).
    - Treatment of the older patient who has become addicted to Oxycontin or other opioids should be done in consultation with an addictions specialist nurse or physician.
        - It is recommended that prescribers avoid opioids and the synthetic opioids (Demerol, Dilaudid, and Oxycontin). Opioids have high potential for addiction and Demerol has been associated with delirium in older adults (CSAT, 2004 [Level VI])
        - Barbiturates should be avoided for use as hypnotics and the use of benzodiazepines for anxiety should be limited to 4 months (U.S. Department of Health and Human Services, 2004 [Level VI])
- Treatment and relapse prevention
    - Monitor pharmacologic treatment such as naltrexone as short-term treatment for alcohol dependence. The benefits of this treatment are dependent on adherence and psychosocial treatment should accompany its use (World Health Organization, 2000 [Level I]). Methadone or buprenorphine should be used for long-term treatment of opioid dependence.
    - Group psychotherapy in limited studies using a cognitive behavioral approach has produced good outcomes with older adults (Payne & Marcus, 2008 [Level III]).
    - Refer to community-based groups such as Alcoholics Anonymous, Narcotics Anonymous, Al-Anon groups, and encourage attendance.
    - Educate family and patient regarding signs of risky use or relapse to heavy or alcohol-dependent behavior.
    - Counsel patient to reduce drug use (harm reduction) and engage in relationship healing or building, community or intellectually rewarding activities, spiritual growth, and so on that increase valued nondrinking rewards.
    - Counsel in the development of coping skills:
        - Anticipate and avoid temptation.

- Learn cognitive strategies to avoid negative moods.
- Make lifestyle changes to reduce stress, improve the quality of life, and increase pleasure.
- Learn cognitive and behavioral activities to cope with cravings and urges to use.
- Encourage development or expansion of patient's social support system.

Follow-up Monitoring

- Evaluate for increase in substance use or misuse associated with growing numbers of aging adults.
- Increase outreach to targeted vulnerable populations.
- Document chronic care needs of older adults diagnosed with substance-related disorders.
- Monitor alcohol use among older adults with chronic pain.
- Communicate findings to all members of the caregiver team.

Definitions:

Levels of Evidence

Level I: Systematic reviews (integrative/meta-analyses/clinical practice guidelines based on systematic reviews)

Level II: Single experimental study (randomized controlled trials [RCTs])

Level III: Quasi-experimental studies

Level IV: Non-experimental studies

Level V: Care report/program evaluation/narrative literature reviews

Level VI: Opinions of respected authorities/consensus panels

AGREE Next Steps Consortium (2009). Appraisal of guidelines for research & evaluation II. Retrieved from http://www.agreetrust.org/?o=1397 .

Adapted from: Melnyck, B. M. & Fineout-Overholt, E. (2005). Evidence-based practice in nursing & health care: A guide to best practice. Philadelphia, PA: Lippincott Williams & Wilkins and Stetler, C.B., Morsi, D., Rucki, S., Broughton, S., Corrigan, B., Fitzgerald, J., et al. (1998). Utilization-focused integrative reviews in a nursing service. Applied Nursing Research, 11(4) 195-206.

## Clinical Algorithm(s)

None provided

# Scope

## Disease/Condition(s)

Substance abuse, including:

- At-risk drinking
- Smoking cigarettes or using smokeless tobacco
- Smoking marijuana
- Prescription or illicit drug misuse
- Heroin or opioid dependence

## Guideline Category

Counseling

Evaluation

Management

Prevention

Risk Assessment

Screening

Treatment

## Clinical Specialty

Family Practice

Geriatrics

Nursing

Psychology

## Intended Users

Advanced Practice Nurses

Allied Health Personnel

Health Care Providers

Hospitals

Nurses

Physician Assistants

Physicians

Psychologists/Non-physician Behavioral Health Clinicians

Substance Use Disorders Treatment Providers

## Guideline Objective(s)

To provide a standard of practice protocol for best nursing practices to care for older persons with drug, alcohol, tobacco, or other drug misuse, abuse, or dependencies

## Target Population

Older persons with drug, alcohol, tobacco, or other drug abuse or dependencies

## Interventions and Practices Considered

Assessment/Evaluation

1. Screening for alcohol, tobacco, and other drug use
2. Use of assessment/screening tools
    - Quantity Frequency (QF) Index
    - Short Michigan Alcohol Screening Test-Geriatric Version (SMAST-G)
    - Alcohol Use Disorders Identification Test (AUDIT)
    - Alcohol Use Disorders Identification Test-Condensed (AUDIT-C)

    - Fagerström Test for Nicotine Dependence
3. Assessment for signs of central nervous system intoxication
    - Individual or collateral data collection
    - Blood alcohol level testing
    - Vital signs
    - Determining respiratory, cardiac, or neurological depression
    - Existing medical conditions, including depression
    - Toxicology screening, if possible
    - Delirium
4. Assessment for at-risk drinking: readiness to change behavior
5. Assessment of acute alcohol withdrawal syndrome
    - Risk factors: previous episodes of detoxification, recent heavy drinking, medical comorbidities (liver disease, pneumonia, and anemia), previous history of seizures or delirium
    - Extreme central nervous system stimulation and a minor withdrawal syndrome
    - Neurological signs with Clinical Institute Withdrawal Assessment for Alcohol, Revised (CIWA-Ar)
6. Assessment of sleep disturbance (Geriatric Depression Scale, Hamilton Anxiety Scale)
    - Neuropsychiatric conditions
    - Sleep history
    - Medication/drug assessment
    - Withdrawal
7. Assessment of level of nicotine dependence

Management/Treatment

1. Personalized feedback on screening assessments
2. Support of self-efficacy and exploring options for change
3. 5 As Intervention for tobacco use
4. Bupropion for smoking cessation
5. Communication of caring and concern
6. Assessment for psychological and physiological alcohol dependence
7. Medical detoxification for alcohol dependence
8. Treatment of acute alcohol withdrawal syndrome (short-acting benzodiazepines)
9. Referral and evaluation of capacity to adhere to referral
10. Methadone, buprenorphine, or naltrexone for heroin or opioid dependence
11. Monitoring of pharmacological treatment
12. Group psychotherapy
13. Community-based support groups
14. Education of family and patient regarding signs of risky use and relapse
15. Patient counseling

## Major Outcomes Considered

- Validity, sensitivity, and positive predictive value of screening tools
- Decreased substance consumption
- Smoking cessation
- Physical health and function
- Quality of life, sense of well-being, and mental health
- Satisfaction with interpersonal relationships
- Productivity and mental alertness
- Falls and other accidents
- Relapse rate
- Morbidity and mortality

# Methodology

## Methods Used to Collect/Select the Evidence

Hand-searches of Published Literature (Primary Sources)

Hand-searches of Published Literature (Secondary Sources)

Searches of Electronic Databases

## Description of Methods Used to Collect/Select the Evidence

Although the Appraisal of Guidelines for Research and Evaluation (AGREE) instrument (described in Chapter 1 of the original guideline document, *Evidence-based Geriatric Nursing Protocols for Best Practice,* 4th ed.) was created to critically appraise clinical practice guidelines, the process and criteria can also be applied to the development and evaluation of clinical practice protocols. Thus, the AGREE instrument has been expanded (i.e., AGREE II) for that purpose to standardize the creation and revision of the geriatric nursing practice guidelines.

The Search for Evidence Process

Locating the best evidence in the published research is dependent on framing a focused, searchable clinical question. The PICO format—an acronym for population, intervention (or occurrence or risk factor), comparison (or control), and outcome—can frame an effective literature search. The editors enlisted the assistance of the New York University Health Sciences librarian to ensure a standardized and efficient approach to collecting evidence on clinical topics. A literature search was conducted to find the best available evidence for each clinical question addressed. The results were rated for level of evidence and sent to the respective chapter author(s) to provide possible substantiation for the nursing practice protocol being developed.

In addition to rating each literature citation as to its level of evidence, each citation was given a general classification, coded as "Risks," "Assessment," "Prevention," "Management," "Evaluation/Follow-up," or "Comprehensive." The citations were organized in a searchable database for later retrieval and output to chapter authors. All authors had to review the evidence and decide on its quality and relevance for inclusion in their chapter or protocol. They had the option, of course, to reject or not use the evidence provided as a result of the search or to dispute the applied level of evidence.

Developing a Search Strategy

Development of a search strategy to capture best evidence begins with database selection and translation of search terms into the controlled vocabulary of the database, if possible. In descending order of importance, the three major databases for finding the best primary evidence for most clinical nursing questions are the Cochrane Database of Systematic Reviews, Cumulative Index to Nursing and Allied Health Literature (CINAHL), and Medline or PubMed. In addition, the PsycINFO database was used to ensure capture of relevant evidence in the psychology and behavioral sciences literature for many of the topics. Synthesis sources such as UpToDate® and British Medical Journal (BMJ) Clinical Evidence and abstract journals such as *Evidence Based Nursing* supplemented the initial searches. Searching of other specialty databases may have to be warranted depending on the clinical question.

It bears noting that the database architecture can be exploited to limit the search to articles tagged with the publication type "meta-analysis" in Medline or "systematic review" in CINAHL. Filtering by standard age groups such as "65 and over" is another standard categorical limit for narrowing for relevance. A literature search retrieves the initial citations that begin to provide evidence. Appraisal of the initial literature retrieved may lead the searcher to other cited articles, triggering new ideas for expanding or narrowing the literature search with related descriptors or terms in the article abstract.

## Number of Source Documents

Not stated

## Methods Used to Assess the Quality and Strength of the Evidence

Weighting According to a Rating Scheme (Scheme Given)

## Rating Scheme for the Strength of the Evidence

Levels of Evidence

Level I: Systematic reviews (integrative/meta-analyses/clinical practice guidelines based on systematic reviews)

Level II: Single experimental study (randomized controlled trials [RCTs])

Level III: Quasi-experimental studies

Level IV: Non-experimental studies

Level V: Care report/program evaluation/narrative literature reviews

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## Methods Used to Analyze the Evidence

Review of Published Meta-Analyses

Systematic Review

## Description of the Methods Used to Analyze the Evidence

Not stated

## Methods Used to Formulate the Recommendations

Expert Consensus

## Description of Methods Used to Formulate the Recommendations

Not stated

## Rating Scheme for the Strength of the Recommendations

Not applicable

## Cost Analysis

A formal cost analysis was not performed and published cost analyses were not reviewed.

## Method of Guideline Validation

External Peer Review

Internal Peer Review

## Description of Method of Guideline Validation

Not stated

# Evidence Supporting the Recommendations

## References Supporting the Recommendations


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## Type of Evidence Supporting the Recommendations

The type of supporting evidence is identified and graded for selected recommendations (see the "Major Recommendations" field).

# Benefits/Harms of Implementing the Guideline Recommendations

## Potential Benefits

Patient

- Improved physical health and function
- Improved quality of life, sense of well-being, and mental health
- More satisfying interpersonal relationships
- Enhanced productivity and mental alertness
- Decreased likelihood of falls and other accidents

Nurse

- Increased accuracy in detecting patient problems related to use/misuse of substances
- More evidence-based interventions resulting in better outcomes

Institution

- Increased number of referrals to ambulatory substance-abuse and mental-health treatment programs
- Improved links with community-based organizations engaged in prevention, education, and treatment of elders with substance-related disorders

### Potential Harms

Buprenorphine and naloxone use requires close collaboration with the prescriber because these drugs should not be abruptly terminated or used with antidepressants, and because they interact negatively with many prescription medications.

## Contraindications

### Contraindications

Bupropion (Zyban) should not be combined with alcohol.

## Implementation of the Guideline

### Description of Implementation Strategy

An implementation strategy is not provided.

### Implementation Tools

Chart Documentation/Checklists/Forms

Mobile Device Resources

For information about availability, see the *Availability of Companion Documents* and *Patient Resources* fields below.

## Institute of Medicine (IOM) National Healthcare Quality Report Categories

### IOM Care Need

Getting Better

Living with Illness

Staying Healthy

### IOM Domain

Effectiveness

Patient-centeredness

## Identifying Information and Availability

## Bibliographic Source(s)

Naegle M. Substance misuse and alcohol use disorders. In: Boltz M, Capezuti E, Fulmer T, Zwicker D, editor(s). Evidence-based geriatric nursing protocols for best practice. 4th ed. New York (NY): Springer Publishing Company; 2012. p. 516-43.

## Adaptation

Not applicable: The guideline was not adapted from another source.

## Date Released

2008 (revised 2012)

## Guideline Developer(s)

Hartford Institute for Geriatric Nursing - Academic Institution

## Guideline Developer Comment

The guidelines were developed by a group of nursing experts from across the country as part of the Nurses Improving Care for Health System Elders (NICHE) project, under sponsorship of the Hartford Institute for Geriatric Nursing, New York University College of Nursing.

## Source(s) of Funding

Hartford Institute for Geriatric Nursing

## Guideline Committee

Not stated

## Composition of Group That Authored the Guideline

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## Financial Disclosures/Conflicts of Interest

Not stated

## Guideline Status

This is the current release of the guideline.

This guideline updates a previous version: Naegle M. Substance misuse and alcohol use disorders. In: Capezuti E, Zwicker D, Mezey M, Fulmer T, editor(s). Evidence-based geriatric nursing protocols for best practice. 3rd ed. New York (NY): Springer Publishing Company; 2008. p. 649-76.

## Guideline Availability

Electronic copies: Available from the Hartford Institute for Geriatric Nursing Web site .

Copies of the book *Evidence-Based Geriatric Nursing Protocols for Best Practice*, 4th edition: Available from Springer Publishing Company, 536 Broadway, New York, NY 10012; Phone: (212) 431-4370; Fax: (212) 941-7842; Web: www.springerpub.com .

## Availability of Companion Documents

The followings is available:

- *Try This*® - issue 17: Alcohol use screening and assessment for older adults. New York (NY): Hartford Institute for Geriatric Nursing; 2 p. 2012. Electronic copies: Available in Portable Document Format (PDF) from the Hartford Institute of Geriatric Nursing Web site .

The ConsultGeriRN app for mobile devices is available from the Hartford Institute for Geriatric Nursing Web site .

## Patient Resources

None available

## NGC Status

This NGC summary was completed by ECRI Institute on June 11, 2008. The information was verified by the guideline developer on August 4, 2008. This summary was updated by ECRI Institute on May 1, 2009 following the U.S. Food and Drug Administration advisory on antiepileptic drugs. This summary was updated by ECRI Institute on July 20, 2009 following the U.S. Food and Drug Administration advisory on Varenicline and Bupropion. This NGC summary was updated by ECRI Institute on June 25, 2013. The updated information was verified by the guideline developer on August 6, 2013. This summary was updated by ECRI Institute on June 2, 2016 following the U.S. Food and Drug Administration advisory on Opioid pain medicines. This summary was updated by ECRI Institute on October 21, 2016 following the U.S. Food and Drug Administration advisory on opioid pain and cough medicines combined with benzodiazepines.

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